SECTION VII - REMITTANCE STATEMENT

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix VIII-C) lists those claims which have been received by EDS Federal but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim only appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix VIII-D) lists those claims which have been received by EDS Federal and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/DENIED	the total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity
AMOUNT PAID	the total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity

WITHHELD AMOUNT	the dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies)
NET PAY AMOUNT	the dollar amount that appears on the check
CREDIT AMOUNT	the dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount)
NET 1099 AMOUNT	the total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix VIII-E).

SECTION VIII - GENERAL INFORMATION - EDS FEDERAL

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS Federal P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS Federal P. O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS Federal P. O. Box 2009 Frankfort, KY 40602 ATTN: Cash/Finance Unit

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
Refund	1. Refund Check 2. Photocopy of the applicable portion of the R/A in question 3. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

When to Call?

- When claim is not showing on paid, pending or denied sections of the R/A within 6 weeks
- When the status of claims are needed and they do not exceed five in number

Where to Call?

- Toll-free number 1-800-372-2921 (within Kentucky)
- Local (502) 227-2525

C. Filing Limitations

New Claims	-	12 months from date of service
Medicare/Medicaid Crossover Claims	-	12 months from date of service NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
Third-Party Liability Claims	-	12 months from date of service NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
Adjustments	-	12 months from date the paid claim appeared on the R/A

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-372-2921 or 1-(502)-227-2525.

Please remit both copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is not necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may not be used in lieu of KMAP claim forms, Adjustment forms, or any other document required by KMAP.

In certain cases it may be necessary to return the Inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

SECTION VIII - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provider Inquiry form:

Field Number	Instructions
1	Enter your 8-digit Kentucky Medicaid Provider Number. If you are a KMAP certified clinic, enter your 8-digit clinic number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid Recipient's Name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medical Assistance ID number.
5	Enter the Billed Amount of the claim on which you are inquiring.
6	Enter the Claim Service Date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and the date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE R/A MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

Field Number	Description
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the R/A (last name first).
3	Enter the complete recipient identification number as it appears on the R/A. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

FAMILY PLANNING SERVICES
APPENDIX

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Ambulatory Surgical Center Services

Medicaid covers medically necessary services performed in ambulatory surgical centers.

Birthing Center Services

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

Dental Services

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

Family Planning Services

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

Hearing Services

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Home Health Services

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies; and durable medical equipment, appliances and certain prosthetic devices on a preauthorized basis. Coverage for home health services is not limited by age.

Hospital Services

Inpatient Services

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits. Reimbursement is limited to a maximum of fourteen (14) days per admission.

Outpatient Services

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

Intermediate Care Facility Services

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.**

*Need for the intermediate level of care must be certified by a PRO.

**Need for the ICF/MR/DD level of care must be certified by the Department for Medicaid Services.

Mental Hospital Services

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Community Mental Health Center Services

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Partial Hospitalization
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

Nurse Anesthetist Services

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

Nurse Midwife Services

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

Pharmacy Services

Legend and non-legend drugs from the approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Pharmacy Services (Continued)

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

Physician Services

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, contact lenses, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Physician Services (Continued)

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

- Ova and Parasites (feces)
- Smear for Bacteria, stained
- Throat Cultures (Screening)
- Red Blood Count
- Hemoglobin
- White Blood Count
- Differential Count
- Bleeding Time
- Electrolytes
- Glucose Tolerance
- Skin Tests for:
  - Histoplasmosis
  - Tuberculosis
  - Coccidioidomycosis
  - Mumps
  - Brucella
- Complete Blood Count
- Hematocrit
- Prothrombin Time
- Sedimentation Rate
- Glucose (Blood)
- Blood Urea Nitrogen (BUN)
- Uric Acid
- Thyroid Profile
- Platelet Count
- Urine Analysis
- Creatinine

Podiatry Services

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

Primary Care Services

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Renal Dialysis Center Services

Renal service benefits include renal dialysis, certain supplies and home equipment.

Rural Health Clinic Services

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

Screening Services

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmental Assessment
- Screening for Urinary Problems
- Screening for Hearing and Vision Problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

Transportation Services

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Vision Services

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS

KenPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services are expected to be available statewide by July 1, 1987. These services are provided by home health agencies.

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family in adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice care waives all rights to certain Medicaid services which are included in the hospice care scope of benefits.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retrospective period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Division of Medical Assistance, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

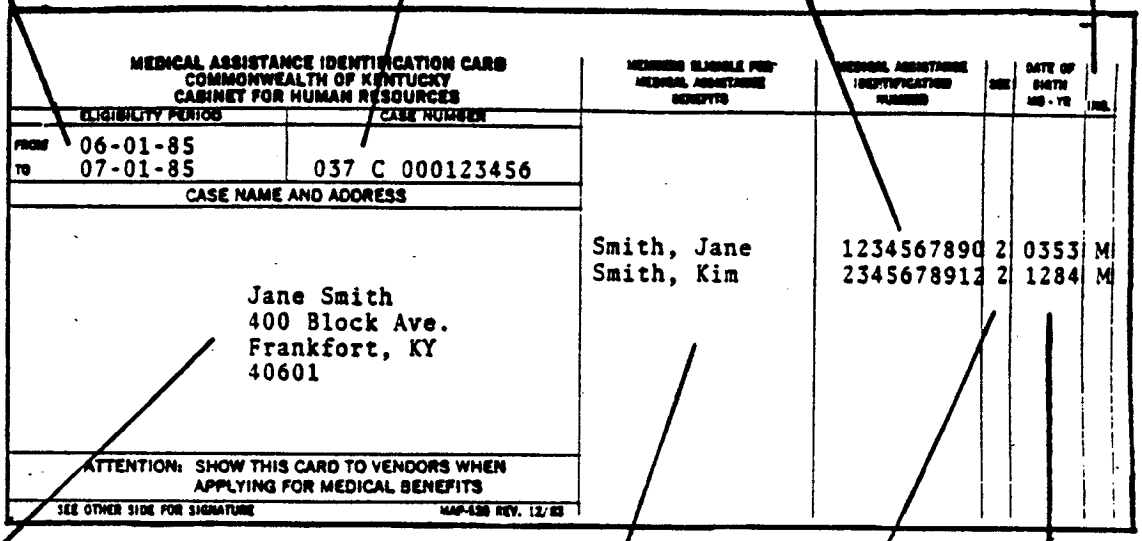
(FRONT OF CARD)

Eligibility Period is the month, day and year of KMAP eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Medical Insurance Code indicates type of insurance coverage.-

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.



MEDICAL ASSISTANCE IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBILITY PERIOD	CASE NUMBER
FROM 06-01-85 TO 07-01-85	037 C 000123456

CASE NAME AND ADDRESS

Jane Smith
400 Block Ave.
Frankfort, KY
40601

MEMBERS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS	MEDICAL ASSISTANCE IDENTIFICATION NUMBER	SEX	DATE OF BIRTH MO-YR	INS.
Smith, Jane	1234567890	2	0353	M
Smith, Kim	2345678912	2	1284	M

ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS

SEE OTHER SIDE FOR SIGNATURE MAP-438 REV. 12/83

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Names of members eligible for Medical Assistance Benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits

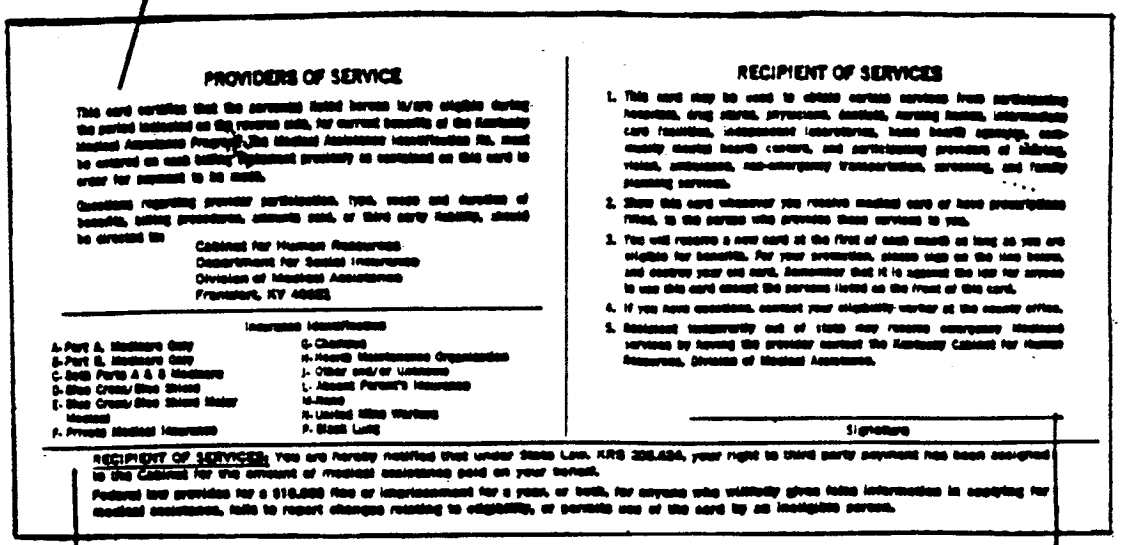
Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
DIVISION OF MEDICAL ASSISTANCE

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers. Insurance Identification codes indicate type of insurance coverage as shown on the front of the card in "Ins." block.



PROVIDERS OF SERVICE

This card verifies that the persons listed herein is/are eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement previously as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

A- Part A, Medicare Only
B- Part B, Medicare Only
C- Both Parts A & B Medicare
D- Blue Cross/Blue Shield
E- Blue Cross/Blue Shield Major Medical
F- Private Medical Insurance
G- Champus
H- Health Maintenance Organization
J- Other and/or Unknown
L- Absent Parent's Insurance
M- None
N- United Mine Workers
P- State Law

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of kidney, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Assistance temporarily out of state may require emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person, if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In Coordinator, by calling 502-564-5560.

You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf

A- Parts A & Medicare Only
B- Part B Medicare Only
C- Both Parts A & B Medicare
D- Blue Cross Blue Shield
E- Blue Cross Blue Shield Major Medical
F- Private Medical Insurance

Insurance Identification
G- Champus
H- Health Maintenance Organization
J- Other and or Unknown
L- Absent Parent's Insurance
M- None
N- United Mine Workers
P- Black Lung

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative | Date

RECIPIENT OF SERVICES

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

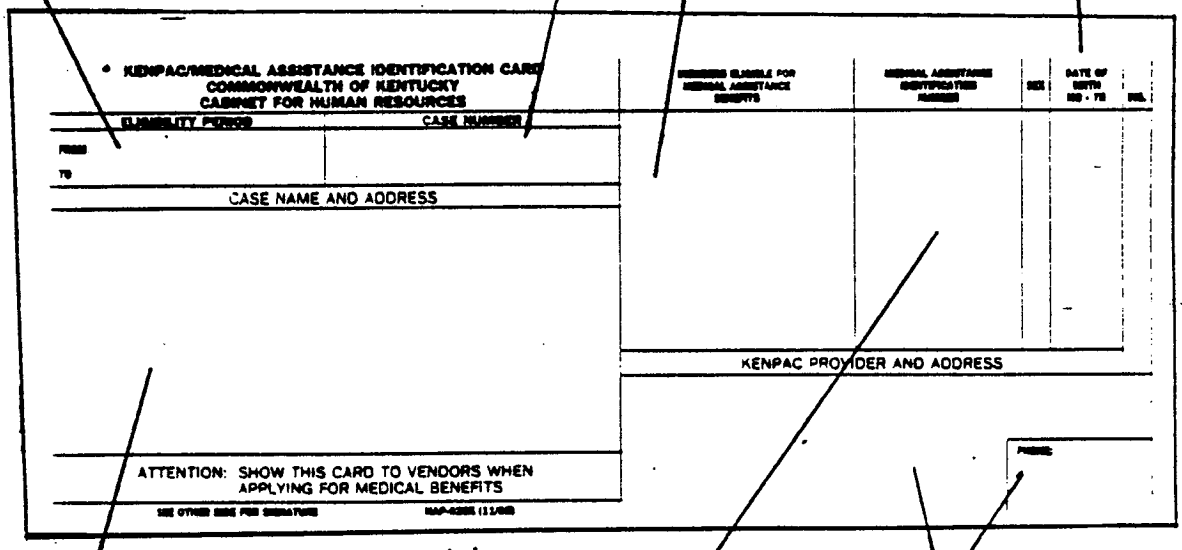
(FRONT OF CARD)

Eligibility Period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Names of members eligible for KMAP. Persons whose names are in this block have the Primary Care provider listed on this card.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.



Case name and address show to whom the card is mailed. This person may be a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care Physician.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

APPENDIX II-C

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDERS OF SERVICE

This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

NOTE: This person is a KenPAC recipient, and you should refer to sections (1) and (2) under "Recipient of Services."

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:

Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, Kentucky 40621

Insurance Identification

A—Part A, Medicare Only
B—Part B, Medicare Only
C—Both Parts A & B Medicare
D—Blue Cross/Blue Shield
E—Blue Cross/Blue Shield Major Medical
F—Private Medical Insurance
G—Champus
H—Health Maintenance Organization
J—Other and/or Unknown
L—Absent Parent's Insurance
M—None
N—United Mine Workers
P—Black Lung

RECIPIENT OF SERVICES

1. The designated KenPAC primary provider must provide or authorize the following services: physician, hospital inpatient and outpatient, home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, and nurse anesthetist. Authorization by the primary provider is not required for services provided by ophthalmologists or board eligible or board certified psychiatrists, for obstetrical services provided by an obstetrician or gynecologist, or for other covered services not listed above.
2. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on reverse side.
3. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers.
4. Show this card to the person who provides these services to you whenever you receive medical care.
5. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.
6. If you have questions, contact your eligibility worker at the county office.
7. Recipient(s) temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Federal law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

HW-343 (Rev. 3/82)

P.L. 92-603 LAWS OF 92nd CONG.--2nd SESS. (As Amended)

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____

2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)

3. _____ _____ _____
City State Zip Code

4. _____
Area Code Telephone Number

5. _____
Pay to, In Care of, Attention, etc. (If different from above)

6. _____
Pay to Address (If different from above)

7. Federal Employer ID Number: _____

8. Social Security Number: _____

9. License Number: _____

10. Licensing Board (If Applicable): _____

11. Original License Date: _____

12. KMAP Provider Number (If Known): _____

13. Medicare Provider Number (If Applicable): _____

14. Provider Type of Practice Organization:

/_/ Corporation (Public) /_/ Individual Practice /_/ Hospital-Based Physician

/_/ Corporation (Private) /_/ Partnership /_/ Group Practice

/_/ Health Maintenance Organization /_/ Profit /_/ Non-Profit

15. If group practice, Number of Providers in Group (specify provider type):

_____

16. If corporation, name, address and telephone number of Home Office:

Name: _____

Address: _____

_____

Telephone Number: _____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership, name and address of Partners:

_____

_____

_____

_____

_____

18. National Pharmacy Number (If Applicable): _____
(Seven-Digit Number Assigned by National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

31. Management Firm (If Applicable)

Name: _____

Address: _____

32. Lessor (If Applicable)

Name: _____

Address: _____

33. Distribution of Beds in Facility -- Complete for all levels of care

	Total Licensed Beds	Total Title XIX Certified Beds
Hospital Acute Care		
Hospital Psychiatric		
Hospital TB/Upper Respiratory Disease		
Skilled Nursing Facility		
Intermediate Care Facility		
ICF/MR/DD		
Personal Care Facility		

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

Name	Address	Percent of Ownership

35. Institutional Review Committee Members (If Applicable):

_____

_____

_____

_____

_____

36. Providers of Transportation Services:

No. of Ambulances in Operation:_____ No. of Wheelchair Vans in Operation:_____
Total No. of Employees:_____ (Enclose list of names, ages, experience & training.)
Current Rates:

A. Basic Rate $_____ (Includes up to _____miles.)
B. Per Mile $_____
C. Oxygen $_____
D. Extra Patient $_____
E. Other _____ $_____

37. Provider Authorized Signature:_____

Name:_____

Title:_____

Date:_____

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

I. Agreement of Participation

After endorsement by the _____ for the

_____ to participate in the

KMAP Family Planning Program, and prior to implementation of the Program, an Agreement of Participation and Statement of Agency Authorization, if applicable, signed by the Appointing Authority, will be submitted to the Director of the Kentucky Medical Assistance Program, Bureau for Social Insurance.

II. Governing Body

The _____ is to serve as the governing body legally responsible for the conduct of the KMAP Family Planning Program.

III. Medical and/or Administrative Director

_____ is to serve as Director and will be responsible for the Family Planning Program and the establishment of administrative policies.

IV. Staff

1. _____ (Nurse) is designated to be responsible for the implementation of the Family Planning Program.

2. The following _____ personnel will participate in the family planning clinics on a regular basis with changes to be made as necessary:

   (List personnel, position classification, and description of assigned duties.)

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

Professional staff will assume responsibility for the technical training of paraprofessional clinic staff and will provide necessary supervision for delegated activities.

3. If physician attendance is deemed necessary, this will be provided by _____, M.D.

V. Available Services

The KMAP Family Planning Program will provide, but not be limited to, the following basic services for eligible recipients:

1. Initial Clinic Visit
2. Revisits by Contraceptive Patients -- Scheduled
3. Annual Visits
4. Follow-up Services
5. Revisits by Patient -- Unscheduled
6. Voluntary Sterilization Counseling
7. Infertility Services
8. Vaginal Infections (Diagnosis and Treatment or Referral)
9. Emergency Services
10. Inpatient Services -- (Affiliation Agreement Only)
11. Pregnancy Testing
12. Referrals

The "Kentucky Medical Assistance Program Policies and Procedures for Family Planning Services" will be used as reference for techniques and procedures.

VI. Referral Responsibility

The clinic shall be responsible for referral to the proper resource in the following circumstances, and for ensuring that the recipient is accepted by the resource to which he/she is referred.

a. Medical problems indicated by history, physical examination, or laboratory or clinical test.

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

b. For pregnancy-related services when appropriate.

c. For social case work not appropriately handled by agency personnel.

VII. Follow-up

When the physician's referral has been completed and returned to the agency, follow-up services will be provided as indicated.

VIII. Equipment and Supplies

Participating clinics shall have the equipment and supplies necessary to provide the services detailed in Section II-C, Available Services --KMAP Policies and Procedures for Family Planning Services."

IX. Program Implementation

1. All Services will be provided as outlined in the KMAP Policies and Procedures Manual.

2. The participating agency will be responsible for notifying eligible recipients regarding appointments or schedules.

3. Clinics will be scheduled in such a manner so as to avoid undue waiting for the patient.

4. Clinic procedures will be developed as deemed advisable by the governing body of the agency.

5. Each member of the nursing staff will be thoroughly familiar with clinic routines to assure continuity of services in case of staff absences.

DEPARTMENT FOR HUMAN RESOURCES
BUREAU FOR SOCIAL INSURANCE
DIVISION FOR MEDICAL ASSISTANCE

ADMINISTRATIVE POLICIES AGREEMENT

X. Medical Records

The _____ shall maintain the required Kentucky Medical Assistance records for each recipient with all entries kept current, dated and signed.

1. Patient History (Medical, Psychiatric and Social)
2. Physical Examination Records
3. Laboratory Report
4. Description of Visits
5. Referral Records
6. Follow-up Records
7. Written consent if a patient is to be sterilized

In addition, appropriate records will be initiated, or existing records used, for each recipient. Results of tests and other services will be recorded as indicated.

1. Retention

All records of recipients will be retained for five (5) years.

2. Availability

All medical and financial records, pertaining to services rendered in the KMAP Family Planning Program, will be made available for review and audit by authorized representatives of the Kentucky Medical Assistance Program.

XI. Policy Revision

Administrative policies of the KMAP Family Planning Services Program will be revised as necessary.

Appendix VI-A

HCPCS Local Family Planning Services
Procedure/Supply Codes

	Physician						
Type of Contraceptive Dispensed - This Visit	Intake or Initial Visit	Medical Revisit or Follow-up Visit With Pelvic Examination	Medical Revisit or Follow-up Visit Without Pelvic Exam.	Counseling Visit	Counseling with a 3 Mo. Supply	Counseling with a 6 mo. Supply	Annual Revisit and Examination
Birth Control Pills	X1110	X1210	X1310	X1410	X1495	X1499	X1510
Intrauterine Device	X1120	X1220	X1320	X1420	-----	-----	X1520
Diaphram	X1130	X1230	X1330	X1430	-----	-----	X1530
Foam/Condoms	X1140	X1240	X1340	X1440	-----	-----	X1540
Rhythm	X1150	X1250	X1350	X1450	-----	-----	X1550
Injection	X1170	X1270	X1370	X1470	-----	-----	X1570
Referral for Sterilization	X1180	X1280	X1380	X1480	-----	-----	X1580
Other(Specify)	X1190	X1290	X1390	X1490	-----	-----	X1590
None Dispensed This Visit	X1100	X1200	X1300	X1400	-----	-----	X1500

HCPCS Local Family Planning Services
Procedure/Supply Codes

Advanced Registered Nurse Practitioner

Type of Contraceptive Dispensed - This Visit	Intake or Initial Visit	Medical Revisit or Follow-up Visit With Pelvic Examination	Medical Revisit or Follow-up Visit Without Pelvic Exam.	Counseling Visit	Counseling Visit with a 3 Mo. Supply	Counseling Visit with a 6 Mo. Supply	Annual Revisit and Examination
Birth Control Pills	X4110	X4210	X4310	X4410	X4495	X4499	X4510
Intrauterine Device	X4120	X4220	X4320	X4420	-----	-----	X4520
Diaphram	X4130	X4230	X4330	X4430	-----	-----	X4530
Foam/Condoms	X4140	X4240	X4340	X4440	-----	-----	X4540
Rhythm	X4150	X4250	X4350	X4450	-----	-----	X4550
Injection	X4170	X4270	X4370	X4470	-----	-----	X4570
Referral for Sterilization	X4180	X4280	X4380	X4480	-----	-----	X4580
Other(Specify)	X4190	X4290	X4390	X4490	-----	-----	X4590
None Dispensed This Visit	X4100	X4200	X4300	X4400	-----	-----	X4500

HCPCS Local Family Planning Services Procedure/Supply Codes

Type of Contraceptive Dispensed - This Visit	Nurse				Other Paramedical Agency Staff			
	Counseling Visit	Counseling Visit With a 3 Mo. Supply	Counseling Visit With a 6 Mo. Supply	Supply Only	Counseling Visit	Counseling Visit With a 3 Mo. Supply	Counseling Visit With a 6 Mo. Supply	Supply Only
Birth Control Pills	X2410	X2495	X2499	-----	X3410	X3495	X3499	-----
Intrauterine Device	-----	-----	-----	-----	-----	-----	-----	-----
Diaphram	-----	-----	-----	-----	-----	-----	-----	-----
Foam/Condoms	X2440	-----	-----	X0024	X3440	-----	-----	X0034
Rhythm	X2450	-----	-----	X0025	X3450	-----	-----	X0035
Injection	-----	-----	-----	-----	-----	-----	-----	-----
Referral for Sterilization	X2480	-----	-----	-----	-----	-----	-----	-----
Other(Specify)	X2490	-----	-----	X0029	X3490	-----	-----	X0039
None Dispensed This Visit	X2400	-----	-----	-----	X3400	-----	-----	-----

[redacted]

APPENDIX VII

FORM APPROVED OMB NO. 0938-00

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

Form HCFA-1500 (1-84) Form OWCP-1500

Form CHAMPUS-501 Form RRB-1500

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN) ☐ BLUE SHIELD

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2 PATIENT'S DATE OF BIRTH

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5 PATIENT'S SEX MALE ☐ ☐ FEMALE

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS)

7 PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED'S EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

TELEPHONE NO.

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO

A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO

B. ACCIDENT AUTO ☐ ☐ OTHER

INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11a CHAMPUS SPONSOR'S STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES

16a IF EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS (1, 2, 3, ETC. OR DX CODE)

1

2

3

4

8 EPSDT YES ☐ ☐ NO

FAMILY PLANNING YES ☐ ☐ NO

PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE CODE (IDENTIFY)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G T.O.S.	H LEAVE BLANK

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)

DATE:

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO

27 TOTAL CHARGE

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO.

31 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

32 YOUR PATIENT'S ACCOUNT NO.

33 YOUR EMPLOYER I.D. NO.

I.D. NO.

34.

35 MAKE PAYMENT TO (SUBSCRIBER A ☐ PHYSICIAN B ☐)

36. CLAIM NO. 547544

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK REMARKS.

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

HEALTH PLAN COPY

PLACE OF SERVICE CODES

1 - (IH)	-	Inpatient Hospital
2 - (OH)	-	Outpatient Hospital
3 - (O)	-	Doctor's Office
4 - (H)	-	Patient's Home
5 -	-	Day Care Facility (PSY)
6 -	-	Night Care Facility (PSY)
7 - (NH)	-	Nursing Home
8 - (SNF)	-	Skilled Nursing Facility
9 -	-	Ambulance
0 - (OL)	-	Other Locations
A - (IL)	-	Independent Laboratory
B - (ASC)	-	Ambulatory Surgical Center
C - (RTC)	-	Residential Treatment Center
D - (STF)	-	Specialized Treatment Facility
E - (COR)	-	Comprehensive Outpatient Rehabilitation Facility
F - (KDC)	-	Independent Kidney Disease Treatment Center

Registration Notification for Advanced Registered Nurse Practitioner

This is to certify that _____ has been certified by _____ (professional organization) to practice in the expanded role of an Advanced Registered Nurse Practitioner (ARNP) in a Family Planning Clinic.

The services provided by _____ (ARNP) in _____ (agency) will be in accordance with the Guidelines for Advanced Registered Nurse Practitioner in a Family Planning Clinic and the Policies and Procedures set forth in the Kentucky Medical Assistance Family Planning Services Manual.

_____
(Physician)

_____
(Advanced Registered Nurse Practitioner)

_____
(Registration #)

_____
(Date)

GUIDELINES FOR THE UTILIZATION OF THE OB/GYN ADVANCED REGISTERED NURSE PRACTITIONER IN A FAMILY PLANNING CLINIC (Cont.)

Policy and Guidelines on Utilization of ARNPs in Family Planning Clinics:

The following guidelines have been developed for the use of community health agencies to effectively utilize the ARNP in providing family planning services. Those agencies receiving Federal monies for the implementation of Family Planning Programs are expected to follow these guidelines.

Prior to providing services within clinics Federally funded for family planning and annually by June 1 thereafter, each Advanced Registered Nurse Practitioner must submit to the Division for Maternal and Child Health Services, Family Planning Program, a copy of his/her current Kentucky registration as an ARNP.

A copy of the medical protocol agreed on by the ARNP and collaborating physician must be submitted to the Division for Maternal and Child Health Services, Family Planning Program. Thereafter, only changes in the protocol must be submitted. The protocol must be comprehensive in nature and be applicable to all normal situations which the Nurse Practitioner may encounter in the Family Planning Clinic. Specific instructions as to oral contraceptive recommended in each situation are to be outlined. Management of minor gynecological problems must be outlined and be specific for the problem.

The medical protocol must be reviewed and updated at least annually by the ARNP and the physician who authorizes her to practice in the expanded role.

Each medical record indicating ARNP services reflecting the expanded role, must be reviewed and co-signed by the collaborating physician. Physician emergency consultation must be readily available for the ARNP providing services in Family Planning Clinics.

GUIDELINES FOR THE UTILIZATION OF THE OB/GYN ADVANCED REGISTERED NURSE PRACTITIONER IN A FAMILY PLANNING CLINIC

Legal Aspects:

The Advanced Registered Nurse Practitioner functions within the framework of the Nurse Practice Act. This act was revised in 1978 and permits the registration of Advanced Registered Nurse Practitioners (KRS 314). The Kentucky Board of Nursing regulation (201 KAR 20:056), sets the requirements for registration as an ARNP. Any registered nurse functioning as a nurse practitioner in a Family Planning Clinic must be registered by the Board in accordance with the regulation. The Board of Nursing regulation (201 KAR 20:057) adopts the Ob/Gyn Nurse Practitioner scope of practice as defined by the certifying organization. Each Ob/Gyn Nurse Practitioner in a Family Planning Clinic is expected to practice in the expanded role within his/her own educational and clinical background and within the role and function definitions as described by NAACOG.

A 1975 joint statement by NAACOG and ACOG on nurse practitioner functions recognizes that the physician cannot under all circumstances be physically present. However, it is essential that the ARNP function within the framework of a medically directed service, with readily available medical collaboration. A current medically approved protocol agreed on by the ARNP and a specific physician must be available at each clinic site where the ARNP practices.

The protocol should provide for all situations expected to be encountered, and should limit the activity of the ARNP to only those duties for which he/she is properly prepared. It shall be the responsibility of the agency as well as the nurse to comply with these legalities. It is imperative that each ARNP provide for himself/herself, or have provided for him/her, liability insurance.

Definition of an Ob/Gyn ARNP:

An Ob/Gyn ARNP is a registered nurse who is qualified through education, experience, and certification by a national certifying body, to provide highly competent and comprehensive nursing services in health maintenance, disease prevention, psycho-social and physical assessment, and management for health-illness needs in the primary care of women. This practitioner functions with considerable independence in initiating and managing clinical services within established regimens, but also functions interdependently with other colleagues in the health care system.

GUIDELINES FOR THE UTILIZATION OF THE ADVANCED REGISTERED NURSE PRACTITIONER (OTHER THAN OB/GYN) IN A FAMILY PLANNING CLINIC

Legal Aspects:

For an Advanced Registered Nurse Practitioner to function in a Family Planning Clinic, he/she must be educationally and clinically prepared to provide family planning and gynecological care. Advanced Registered Nurse Practitioners who have been prepared in specialities other than Ob/Gyn must practice only within the limitations of their specialty designation under a clearly defined medical protocol agreed on by the ARNP and the supervising physician. The protocol must be available at the clinic site. The regulation defining the registration process (201 KAR 20:056) Section 10 (9) limits the nurse practitioner's practice to the specialty to which he/she has been designated and the regulation 201 KAR-20:057 adopts the nurse practitioner scopes of practice defined by the certifying organizations, such as ANA, NAPNAP.

The Family Nurse Practitioner and the Pediatric Nurse Practitioner or Associate may have had a preparation component in women's/adolescent health care. It is imperative that the ARNP designated as a Family Nurse Practitioner or Pediatric Nurse Practitioner function in a Family Planning Clinic only within her educational and clinical preparation. Such ARNP and his/her supervising physician will be responsible for clearly defining the expected role in a Family Planning Clinic only within these parameters. It is essential that each Advanced Registered Nurse Practitioner provide for himself/herself or have provided for him/her, liability insurance for the expanded role.

Policy and Guidelines on Utilization of ARNPs in Family Planning Clinics

The following guidelines have been developed for the use of community health agencies to effectively utilize the ARNP in providing family planning services. Those agencies receiving Federal monies for the implementation of Family Planning Programs are expected to follow these guidelines.

Prior to providing services within clinics Federally funded for family planning and annually by June 1 thereafter, each Advanced Registered Nurse Practitioner must submit to the Division for Maternal and Child Health Services, Family Planning Program, a copy of his/her current Kentucky registration as an ARNP. His/her specialty designation (Family Nurse Practitioner, Pediatric Nurse Practitioner, etc.) must also be identified.

GUIDELINES FOR THE UTILIZATION OF THE ADVANCED REGISTERED NURSE PRACTITIONER (OTHER THAN OB/GYN IN A FAMILY PLANNING CLINIC (Cont.)

A copy of the medical protocol agreed on by the ARNP and collaborating physician must be submitted to the Division for Maternal and Child Health Services, Family Planning Program. Thereafter, only changes in the protocol must be submitted. The protocol must be comprehensive in nature and be applicable to all normal situations which the Advanced Registered Nurse Practitioner may encounter in the Family Planning Clinic. Specific instructions as to oral contraceptive recommended in each situation are to be outlined. Management of minor gynecological problems must be outlined and be specific for the problem.

The medical protocol must be reviewed and updated at least annually by the ARNP and the physician who authorizes him/her to practice in the expanded role.

Each medical record indicating ARNP services reflecting the expanded role, must be reviewed and co-signed by the collaborating physician.

Physician emergency consultation must be readily available for the ARNP providing services in Family Planning Clinics.

REGISTRATION NOTIFICATION

FOR

ADVANCED REGISTERED NURSE PRACTITIONER-NURSE MIDWIFE

THIS IS TO CERTIFY THAT _____ (ARNP-CNM) HAS BEEN CERTIFIED BY _____ AND THE KENTUCKY BOARD OF NURSING
(professional organization)
TO PRACTICE IN THE EXPANDED ROLE OF AN ADVANCED REGISTERED NURSE PRACTITIONER-NURSE MIDWIFE.

THE SERVICES PROVIDED BY _____ (ARNP-CNM) WILL BE IN ACCORDANCE WITH THE POLICIES AND PROCEDURES SET FORTH IN THE KENTUCKY MEDICAL ASSISTANCE NURSE MIDWIFE SERVICES MANUAL.

PHYSICIAN _____
(signature)

ARNP-CNM _____
(signature)

_____
KY. Registered Nurse License Number

_____
ARNP-CNM Certification Number

_____
Date

MEDICAL PROTOCOL ON FILE?
YES____ NO_____

DO YOU HAVE A VALID PERMIT TO PRACTICE MIDWIFERY IN THE STATE OF KENTUCKY?

YES____ NO____

CERTIFICATE NUMBER_____

MAP-347
(6/83)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
STATEMENT OF AUTHORIZATION
(Please Print All Requested Information)

I hereby declare that I, _____ (Licensed Professional),

have entered into a contractual agreement with _____ (Facility Name)

_____ (City, State, Zip)

to provide professional services. I authorize payment to _____ (Facility Name)

_____, from the Kentucky Medical Assistance Program for covered services rendered by me and specified by the criteria of our contract. I understand that I, personally, cannot bill the Kentucky Medical Assistance Program for any service that is reimbursed to

_____ (Facility Name) as part of our contractual agreement.

_____ Signature of Professional

_____ Date Signed

_____ License and/or Certification Number

_____ Specialty

_____ Date Contract Effective

AS OF 01/06/84 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: FAMILY PLANNING SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSON R	3834042135	9883324-552-580	111783-111783	50.00	2.00	0.00	48.00	365
01 PS 6	PROC 01234	QTY 1		111783-111783	30.00	0.00		30.00	61
02 PS 6	PROC 12345	QTY 1		111783-111783	20.00	2.00		18.00	365

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 50.00 TOTAL PAID: 48.00

APPENDIX VIII-A

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: FAMILY PLANNING SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
023104	JONES R	4321712345	9838348-552-010	111783-111783	30.00	254
01 PS 6	PROCEDURE 11122 QTY 1			111783-111783	30.00	

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 30.00

APPENDIX VIII-B

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: FAMILY PLANNING SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

061	PAID IN FULL BY MEDICAID
254	THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
260	ELIGIBILITY DETERMINATION IS BENG MADE
365	FEE ADJUSTED TO MAXIMUM ALLOWABLE
999	REQUIRED INFORMATION NOT PRESENT

PROVIDER INQUIRY

APPENDIX VIII

EDS FEDERAL

FISCAL AGENT OF KMAP

P.O. BOX 2009

FRANKFORT, KY 40602

Attention: Provider Services

PROVIDER NAME AND ADDRESS

PROVIDER NUMBER:

1. TYPE OF CLAIM (CHECK ONE)

1. ☐ HOSPITAL-INPATIENT
2. ☐ HOSPITAL-OUTPATIENT
3. ☐ LONG TERM CARE
4. ☐ PHYSICIAN
5. ☐ HOME HEALTH
6. ☐ PRIMARY CARE
7. ☐ VISION
8. ☐ DENTAL
9. ☐ TRANSPORTATION
10. ☐ PHARMACY
11. ☐ MEDICARE X-OVER
12. ☐ OTHER _____

2. RECIPIENT NAME (LAST, FIRST, MI.)	3. MEDICAL ASSISTANCE NUMBER		
4. INTERNAL CONTROL NUMBER (ICN)	5. CLAIM SERVICE DATE	6. RA DATE — —	7. YOUR ACCOUNT NUMBER

8. PROVIDER'S MESSAGE

SIGNATURE DATE

9. MEDICAID RESPONSE

APPENDIX IX

MAIL TO: EDS FEDERAL CORPORATION
P.O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)	EDS FEDERAL USE ONLY		
2. Recipient Name	3. Recipient Medicaid Number		
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service	
	7. Billed Amt.	8. Paid Amt.	9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature

13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

PROVIDER INQUIRY FORM

APPENDIX X

EDS
P.O. Box 2009
Frankfort, Ky. 40602

Please remit **both** copies of the Inquiry Form to EDS.

1. Provider Number	3. Recipient Name (first, last)
2. Provider Name and Address	4. Medical Assistance Number
	5. Billed Amount / 6. Claim Service Date
	7. RA Date / 8. Internal Control Number
9. Provider's Message	

10. _____
Signature Date

Dear Provider:

_____ This claim has been resubmitted for possible payment.

_____ EDS can find no record of receipt of this claim. Please resubmit.

_____ This claim paid on _____ in the amount of _____.

_____ We do not understand the nature of your inquiry. Please clarify.

_____ EDS can find no record of receipt of this claim in the last 12 months.

_____ This claim was paid according to Medicaid guidelines.

_____ This claim was denied on _____ for EOB code _____

_____

_____ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other: _____

_____

_____

_____

_____

_____
EDS Date